DUKE UNIVERSITY MEDICAL CENTER AND HEALTH SYSTEM IDENTIFICATION

Applicant to Complete:
Card Request Type: □ First Card □ Lost/Stolen □ Damaged □ Information Change □ Renewal
ID Only Card Request $6: □ First Name Only □ First & Last Name Only

First Name: __________________________ MI: _____ Last Name: __________________________

DUID: __________________________ Applicant Signature: __________________________

I certify the information that I have provided above is correct

Department Head, Manager or Payroll Clerk to Complete:
Dept./Unit/Church: __________________________
Verified Credentials (9 char max): __________________________
Prox Chip Required for bldg. access? □ No □ Yes (add'l fee)
Authorizing Dept. Phone #: __________________________

4-Year Expiration
□ Employee
□ House Staff
□ Student

1-Year Maximum Expiration
□ Volunteer/Contractor (circle one)
□ Visiting Faculty/Staff/Observer
□ Clergy/Other

Expiration Date (required): __________________________

R/3 Company #: ____________ Cost Object #: ____________ Type (circle one): CC / PC / WBS / GL Acct: __________________________

Approval Signature: __________________________ DUID: __________________________

I certify the information provided above is correct and I have verified the person listed is entitled to receive this ID Card.

Print Name & Title: __________________________

Card Office to Complete:
Card Type: □ Medical Center □ Health System □ Other: __________________________ HID #: __________________________
Payment Type: __________________________ Amount: __________________________ Date: __________________________ Time: __________________________ Staff: __________________________

Updated: 08/2018